MODEL AUTHORIZATION

FOR THE USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

I authorize the use and disclosure of my health information as described below:

1. **This authorization applies to the following information:**

_____

_____

2. **I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my health information:**

_____

_____

3. **I authorize the following persons (or class of persons) to receive my health information:**

_____

_____

4. **This authorization expires:** _____
Insert a date or an event

You may revoke this authorization at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the address at the foot of this form. You may deliver your revocation by any means you choose (e.g., personally or by mail), but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this authorization.

If you have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected.

_____

☐ ***If this box is checked, we are requesting this authorization in order to enable us to use or disclose health information that we maintain, and the following additional provisions apply:***

You may refuse to sign this authorization.

*We will not condition treatment, payment, enrollment or eligibility for benefits on your providing or refusing to provide this authorization.**

***** This does not apply if we are seeking this authorization in order (i) to conduct research-related treatment, (ii) to obtain information in connection with your eligibility or enrollment in a health plan of which you are not already a member, (iii) to enable us to determine our obligation to pay a claim, or (iv) to create health information to provide to a third party. Under no circumstances, however, are you required to authorize the disclosure of psychotherapy notes.

You are entitled to a copy of this authorization—please be sure to ask for one

We are requesting this authorization in order to use or disclose your health information for the following purposes:

_____

_____

You may inspect or copy the information we are planning to use or disclose in accordance with our procedures for information access.

☐ ***If this box is checked, we are requesting this authorization in order to enable us to disclose your health information to a health plan or provider for treatment, payment or operational purposes, and the following additional provisions apply:***

You may refuse to sign this authorization.

*We will not condition treatment, payment, enrollment or eligibility for benefits on your providing or refusing to provide this authorization.**

We are requesting this authorization in order to disclose your health information for the following purposes:

_____

_____

☐ ***If this box is checked, we will receive compensation for our use or disclosure of your health information.***

_____

AUTHORIZATION

I understand and agree to the foregoing:

Sign: _____ Date: _____

Print name of patient: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____

***** This does not apply if we are seeking this authorization in order (i) to conduct research-related treatment, (ii) to obtain information in connection with your eligibility or enrollment in a health plan of which you are not already a member, (iii) to enable us to determine our obligation to pay a claim, or (iv) to create health information to provide to a third party. Under no circumstances, however, are you required to authorize the disclosure of psychotherapy notes.

You are entitled to a copy of this authorization—please be sure to ask for one

REVOCATION

I hereby revoke the authority given above.

If the revocation is limited (for example, you want us to stop disclosing some but not all of the information described above), please describe the limitations here. If you leave this part blank, we will treat the revocation as complete.

Limitations: _____

Sign: _____ Date: _____

Print name of patient: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____

Address for revocation: Your revocation will be effective once it is received at the following address:

_____

_____

_____